UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

WILLARD L. SLOAN, EUGENE J. WINNINGHAM, and JAMES L. KELLEY, on behalf of themselves and a similarly situated class,

Plaintiffs,

v.

BORGWARNER, INC., BORGWARNER FLEXIBLE BENEFITS PLANS and BORGWARNER DIVERSIFIED TRANSMISSION PRODUCTS, INC.,

Defendants.
_____/

Case No. 09-cv-10918
Hon. Paul D. Borman
Magistrate Mona K. Majzoub

Class Action

EXHIBIT 30

TO

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AS TO LIABILITY

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

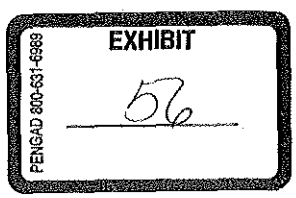
BORGWARNER DIVERSIFIED TRANSMISSION PRODUCTS, INC.,
v.

UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENTS WORKERS OF AMERICA, LOCAL NO. 287, et al.

CIVIL ACTION NO. 1:06CV0058

UAW LOCAL 287'S APPENDIX IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO BORGWARNERS' MOTION FOR SUMMARY JUDGMENT

Hourly Retirees Insurance Booklet Draft
dated March 24, 1987



Interoffice Memo

Borg-Warner Corporation | 100 South Wacker Drive | Chicago Illinois 60606 | Telephone 312 782 9700

BorgWarner

Date March 24, 1987

Subject Hourly Retirees Insurance Booklet Draft

From Bill Studlow

To Dick Nuerge

Enclosed is a draft of the insurance booklet for your hourly retirees prior to October 1, 1986.

Omitted from the draft are the Dental, Hearing and Substance Abuse plans. Included are Organ or Tissue Transplant, Mandatory Second Surgical Opinion and Medical Case Management benefits. If a benefit is included that should not be, please so indicate on the draft.

If the retiree benefits detailed in this draft are the same as the benefits listed in the retiree section of the active employee booklet, you may want to forego this draft and order additional employee booklets for distribution to the pre-10/1/86 retirees.

Dick, if you have any questions do not hesitate to contact me.

Bill

BS:ds//4802G
Enclosure

cc: Marty Burghgraef

CONTENTS

Dear Transmission Systems Retirees:

The Basic Hospital and Medical Benefits listed on the Plan of insurance page and explained in the pages that follow is designed to provide protection from the financial burden a serious illness or accident often imposes and includes liberal life insurance coverage.

The full cost of all health insurance is paid by the Company along with certain Life Insurance coverages based on your date last worked and your years of service.

Richard A. Nuerge
Manager
Insurance & Pensions Department
Transmission Systems

PLAN OF INSURANCE

FOR YOU AND YOUR DEPENDENTS

BASIC HOSPITAL AND MEDICAL BENEFITS

Life Insurance	Daily Hospital Benefit Up to	Extra Hospital Charges	Surgical Expenses Up to	In-Hospital Medical Expense	X-Ray and Laboratory Expenses Up to	Major Medical Expense Up to**	All Out-Patient Surgery
*	Usual and Customary Cost of Semi-Private Room	** Usual and Customary	** Usual and Customary	** Usual and Customary	** Usual and Customary	$200,000	Paid at 100%

* Employees Retired on/after 3/1/74 keep Full Life amount in effect the day prior to retirement until age 65, then Life reduces per schedule described on following pages. Employees retired on Total and Permanent Disability Pension also keep the Transition and Bridge benefit until age 65.

Employees Retired prior to 3/1/74 have retired Life benefits as described in booklets and Health Insurance Agreements applicable at the time of retirement. (Effective 4/1/81 these amounts are increased by $500.)

\+ Basic Hospitalization and Medical benefits also include:
- Prolonged Attendance Benefits
- Examination of a Newborn
- Physiotherapy Benefits
- Radiation Therapy Benefits
- Convalescent and Long Term Illness Benefits
- Out-Patient Psychiatric Care Benefits
- Prescription Drug Benefits
- Chemotherapy Benefits
- Medical Emergency Benefits
- Vision Care Benefits
- Mail Order Drug Plan - see your Benefit Administrator for further information.

IN HOSPITAL

** For those retirees/survivors and their dependents under age 65: your combined 10 percent copayment share (or 20 percent under Major Medical) of ~~Inpatient~~ Expenses ~~and Miscellaneous~~ expenses incurred during a calendar year will not exceed $300 per individual nor $600 for all insured family members. When these limits are reached, plan payments for ~~Inpatient and Miscellaneous~~ expenses increase from 90 percent (or 80 percent under Major Medical) to 100 percent for the remainder of the calendar year.

NOSPITAL

Expenses counted towards the stop-loss limits only include your 10 percent share (or 20 percent under Major Medical) of covered items.

Stop Loss

add level for retirees 65+ ($175 & $350)

PLAN OF INSURANCE (Continued)

These items do not count towards the stop-loss limits:

- the amount you pay for the ~~Miscellaneous~~ MAJOR MEDICAL deductible,
- the amount the plan reimburses for any covered expense, and
- any expense not covered by the plan.

If stop-loss expenses are incurred in December, they are credited to your stop-loss limits in that year and in the following calendar year.

Any Retired employee or dependent (other than a newborn child) who is confined in a hospital on the date a new or increased benefit is to become effective will not become insured for that benefit until discharged from the hospital.

For those retirees/survivors who have Medicare: Your combined 10 percent copayment share (or 20 percent under Major Medical) of ~~Inpatient expenses and Miscellaneous~~ IN HOSPITAL expenses incurred during a calendar year will not exceed $175 for any individual nor $350 for all insured family members. When these limits are reached, plan payments for ~~Inpatient and Miscellaneous~~ IN HOSPITAL expenses increase from 90 percent (or 80 percent under Major Medical) to 100 percent for the remainder of the calendar year.

Expenses counted towards the stop-loss limits only include your 10 percent share (or 20 percent under Major Medical) of covered items.

THESE ITEMS DO NOT COUNT TOWARDS THE STOP-LOSS LIMITS:

- the amount you pay for the ~~Miscellaneous~~ MAJOR MEDICAL deductible,
- the amount the plan reimburses for any covered expense, and
- any expense not covered by the plan.

If stop-loss expenses are incurred in December, they are credited to your stop-loss limits in that year and in the following calendar year.

SECTION I - LIFE INSURANCE BENEFITS

A. Normal Retirement Benefits

If you retire under the Normal Retirement provisions of the Company Retirement Income Agreement on or after April 1, 1974, a portion of your Group Life Insurance will be continue at no cost to you as outlined below. (Your Normal Retirement Date will be your 65th birthday or the first of the month following the month of attaining age 65.)

1. For employees retired on or after April 1, 1974 but prior to April 1, 1980.*

(a) If you hare 20 years or more of Continuous Service, the amount continued is determined as follows:

	Year of Retirement		
	1st Year	2nd Year	3rd Year and thereafter
	$4,800	$4,200	$3,600

(b) If you have 10 through 19 years of Continuous Service,

	Year of Retirement		
	1st Year	2nd Year	3rd Year and thereafter
	$3,600	$3,000	$2,400

* Effective 4/1/81 the amounts shown in (a) and (b) above will be increased by $500.

2. For Employees retired on or after April 1, 1980.

(a) If you hare 20 years or more of Continuous Service, the amount continued is determined as follows:

	Year of Retirement		
	1st Year	2nd Year	3rd Year and thereafter
	$5,400	$4,800	$4,200

(b) If you have 10 through 19 years of Continuous Service,

	Year of Retirement		
	1st Year	2nd Year	3rd Year and thereafter
	$4,200	$3,600	$3,000

B. Early Retirement Benefits

If you retire early under the provision of the Retirement Income Agreement you may elect to continue your amount of insurance in effect on the day preceding your retirement date by completing an agreement to pay the required contribution for such amount of insurance. When you reach age 65 or cease to make the required contribution, whichever is earlier, your amount of insurance will be determined in accordance with the schedule outlined under A. above.

By Special Agreement for those employees retired on or after March 1, 1974 and effective July 1, 1974, employees who maintained their full life insurance amount in force for the above provision and those retired on or after July 1, 1974 will have their life insurance amount in effect immediately prior to retirement continued in that amount until age 65. At age 65 the amount reduces in the three steps outlined under Normal Retirement A. above.

C. Disability Retirement Benefits Life

If you become totally and permanently disabled and retire under the Total and Permanent Disability Retirement provisions of the Transmission Systems Retirement Income Plan Agreement the full amount of Life Insurance in effect on the date of such disability retirement will be continued until your Normal Retirement Date at which time Life Insurance will be reduced in accordance with the schedule outlined under A. above.

D. Limitations

Such Life Insurance will be continued only while the insured plan continues in effect and while the insurance plan remains unchanged in this respect.

An employee who qualifies under the provisions of this section and who retires under the Transmission Systems Retirement Income Plan Agreement shall be considered an employee for Group Life Insurance purposes; therefore, the Conversion Privilege shall not apply to those so retiring.

Employees who terminate their employment with the Company and who are entitled to Vested Deferred Retirement Benefits are not eligible for continued Life Insurance Benefits.

SECTION II - BASIC HOSPITAL AND MEDICAL BENEFITS

Hospital Confinement Benefits

When benefits are payable

Benefits are payable for confinement in a legally constituted hospital as a result of an accidental bodily injury or illness not connected with employment. Such confinement must be for at least the minimum period specified below and must be recommended by a legally qualified physician.

Cause of Confinement	Minimum Period of Confinement
Surgery	None Required.
Sickness	None Required, if treated in hospital for any unforeseen acute sickness requiring treatment of an emergency nature, otherwise a registered bed patient.
Injury	None Required, if emergency care is rendered, otherwise a registered bed patient.

How much does plan pay?

(a) You will be paid 90% for the following subject to the Stop Loss limits shown on page 2 in this booklet:

1. The usual and customary cost of the Room and Board charge if confinement is in a ward or semi-private room (including nursery charges of an insured newborn child), or if a private room is used, the allowance will be equal to the hospital's average charge for a two-bed room.

2. The usual and customary allowances for other hospital expenses which are recommended by a legally qualified physician, provided such expenses are incurred during a confinement period for which Room and Board benefits are payable. However, expenses for ambulance service will be payable on the basis of the following schedule:

   a. Within city limits - up to $50.00.
   b. Within 50 miles radius - up to $100.00.
   c. Over 50 mile radius - up to $150.00.

   Effective April 1, 1982 this ambulance benefit will include medically necessary ambulance services from one hospital to another hospital or to a CAT SCAN Facility if such hospital does not have CAT SCAN Facilities.

How much does plan pay? (Continued)

3. The actual charge if confinement is to a hospital intensive care, coronary care or isolation unit on a day for which the insured person would otherwise be entitled to benefits for hospital room and board. (This benefit will be paid in lieu of any room and board benefit for that day.)

(b) You will be paid 100% of the usual and customary charges for hospital charges in connection with outpatient surgery or outpatient treatment of injury in the emergency room or outpatient department of a hospital.

"Hospital intensive care or coronary care unit" shall mean only a section ward or wing within the hospital which is distinguishable from the other hospital facilities because it

(a) is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients including constant observation and care by a Registered Nurse (R.N.) or other highly trained hospital personnel and

(b) has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.

The term shall not include any hospital facility maintained for the purposes or providing normal post-operative recovery or service.

How long?

The plan will pay benefits for as long as 365 days for any one period of confinement, except this maximum period will be reduced by one day for each two days of confinement in an extended care facility for the same condition.

Successive periods of confinement to a hospital and/or an extended care facility due to the same or related cause will be considered as one period of confinement.

Maternity benefits

For purposes of determining the amounts of benefits payable, no distinction is made between confinement for maternity and confinement for other reason.

Not covered by hospital benefits

Surgical, medical or nursing fees; charges for the purchase of braces, appliances or ambulatory apparatus; charges for the rental of braces, appliances, or ambulatory apparatus during any one period of hospital confinement which, when added to all previous charges for such rental during such period of hospital confinement, are in excess of the price normally charged by the hospital for the purchase of any such equipment; blood or blood derivatives; confinements and charges not recommended and approved by a legally qualified physician.

Surgical Benefits (You will be paid 90% for the following, subject to the Stop Loss limits shown on page 2 in this booklet.)

When benefits are payable

Benefits are payable for any surgical procedure performed by a legally qualified physician as a result of an accidental bodily injury or illness not connected with employment.

Hospital confinement is not necessary.

How much?

Payment will be made on a Usual and Customary basis.

In determining what constitutes Usual and Customary, the Insurance Company will take into consideration:

1. The usual fee which the individual physician most frequently charged to the majority of his patients for a similar procedure or service.

2. The fees which fall within the customary range of fees charged in a locality by most physicians of similar training and experience for the performance of a similar procedure or service.

3. Unusual circumstances or medical complications requiring additional time, skill and experience in connection with the procedure or service.

In the absence of unusual circumstances or medical complications as referred to in "3" above, the usual and customary fee will be deemed not to exceed the lesser of "1" and "2" above.

Mandatory Second Surgical Opinion

This part of the plan will also pay for a mandatory second surgical opinion under the following conditions:

If an elective, non-emergency surgical procedure is recommended, a second surgical opinion on the need for that procedure must be obtained, before surgery, if that procedure is on the list that follows:

An elective, non-emergency surgical procedure means a surgical procedure:

(a) that can be done at the doctor's or patient's convenience;
(b) for which a person has a choice of whether or not to have it done.

Mandatory Second Surgical Opinion (Continued)

List of Procedures

1. Bunionectomy (removal of bunion)
2. Cataract removal and/or intraocular implant
3. Cholecystectomy (removal of gall bladder)
4. Coronary bypass
5. Dilation and Curettage (D & C)
6. Hemorrhoidectomy (removal of hemorrhoids)
7. Herniorrhaphy (hernia repair)
8. Hysterectomy (removal of uterus)
9. Knee surgery (including excision of knee cartilage)
10. Laminectomy (removal of part of vertebrae)
11. Ligation and stripping of varicose veins
12. Mastectomy and other breast surgery
13. Prostatectomy (removal of part or all of prostate gland)
14. Submucous resection (repair of deviated septum)
15. Tonsillectomy and/or adenoidectomy

The Second Surgical Opinion must be:

(a) in writing;
(b) by a board certified specialist in the specialty of the proposed procedure, who personally examines the patient and who is not associated with the first doctor who recommended surgery;
(c) given after the first opinion by another doctor on the need for the same procedure.

Covered Charges for a Mandatory Second Surgical Opinion include:

(a) charges of the doctor who offers the second opinion;
(b) charges for diagnostic x-ray and laboratory exams used by the doctor to form the opinion.

Benefits for covered charges for a mandatory second surgical opinion will be paid in full. This amount will be paid for not more than two second opinions for the same procedure after the procedure was first recommended. Each opinion must be by a different doctor.

This benefit is in place of all other benefits for the same charges which could be paid elsewhere under the plan.

If you do not obtain a Mandatory Second Surgical Opinion as required, charges of the doctor who does the surgery will be limited to 50% of the amount that would have been considered for payment if the opinion had been obtained.

On request, Equitable will provide names of board certified specialists so that the patient will be able to comply with this Mandatory Second Surgical Opinion requirement. (If specialists are unavailable in your area, you will be given names of other qualified doctors to satisfy this requirement.)

Mandatory Second Surgical Opinion (Continued)

Many of the items listed above can be provided either while confined in a medical facility or on an out-patient basis. If you have a choice, you are encouraged to receive these services on an out-patient basis. In this way you help reduce the cost to the plan by eliminating unnecessary confinement and you become entitled to 100 percent reimbursement.

Technical surgical assistance

In the event that necessary technical surgical assistance is not available as a service provided by an intern, resident physician or house officer of the hospital in which an operation is performed, the surgeon or surgeons rendering necessary surgical assistance to the surgeon performing the operation will be paid on a Usual and Customary basis.

Generally, to be payable, the nature of the operation would be such that the skills of more than one "Surgeon" are needed to carry-out the surgery for this benefit to be payable.

Corrective cosmetic procedures
Benefits will be paid for cosmetic surgical procedures provided the surgery is for the correction of (a) congenital anomalies while the individual is less than 12 years of age unless medical necessity for delaying the procedure is clearly established, or (b) conditions resulting from accidental injuries or traumatic scars.

Obstetrical benefits

Benefits for an obstetrical procedure will be paid on a Usual and Customary basis. Such benefits shall be inclusive of pre- and post-natal care.

Not covered for surgical benefits

Surgical fees for dental work or treatment except for removal of unerupted teeth or for multiple extractions if a patient is confined to a legally constituted hospital with a concurrent hazardous medical condition.

In-Hospital Medical Expense Benefits (You will be paid 90% for the following subject to the Stop Loss limits shown on page 2 in this booklet.)

Benefits for doctor's visits

Benefits are payable for the charges incurred as the result of a legally qualified physician's visit to you or your dependents during a period of hospital confinement as a registered bed patient because of accidental bodily injury or illness not connected with employment.

How much?

Payment will be made on a Usual and Customary basis. Usual and Customary is defined under Surgical Benefits.

How much? (Continued)

When surgery is performed, payment will be made for visits by a physician prior to surgery, regardless of whether the same physician performs the surgery. After the surgery is performed, payment will be made for visits by a physician when such physician is not the one who performed the surgical procedure.

Bedside consultation

In addition to the above you will be paid, on a Usual and Customary basis, for bedside consultation during a period of hospital confinement when rendered by a physician other than your attending physician but only when such consultation is required by the attending physician as necessary for diagnosis and treatment of an injury or illness not connected with employment.

Consultations rendered by hospital staff members or required by hospital rules and regulations are not covered.

Not covered

Physicians' charges for visits following a surgical operation unless the physician is not the one who performed or assisted in the performance of the operation; for expenses incurred for eye or hearing examinations, treatment of the teeth or periodontium unless the visits are made for treatment of an injury; drugs, dressings or medicines.

No payment will be made for In-Hospital Medical Care of a newborn child unless the charges are incurred for treatment, other than routine pediatric care, made necessary because of (a) premature birth, (b) abnormal congenital condition, or (c) a diagnosed sickness or injury. (A newborn child will be considered to have been born prematurely if the weight of such child at birth is less than 5 1/2 pounds).

Prolonged Attendance Benefits (You will be paid 90% for the following, subject to the Stop Loss limits shown on page 2 in this booklet.)

How much

If an injury or illness is such that life is in danger and special medical skills and supervision are required which cannot be rendered by personnel employed by the hospital, but only by your attending physician, you will be paid for the fees charged for the prolonged attendance of your attending physician up to a maximum of $16.00 for each hour following the first full hour of continuous attendance during one period of hospital confinement. Pro rata adjustments will be made for periods of attendance of less than a full hour.

Such benefits are in lieu of Benefits for Doctor's Visits described above.

Not covered

No payment will be made for attendance that is not required by the patient's critical state or following a surgical operation unless the physician is not the one who performed or assisted in he performance of the operation. In addition no payment will be made for eye or hearing examinations, treatment of the teeth or periodontium unless attendance is required for treatment of an injury, drugs, dressings or medicines.

Examination of a Newborn (You will be paid 90% for the following, subject to the Stop Loss limits shown on page 2 in this booklet.)

How much

Benefits will be paid up to $15.00 for the routine examination of a newborn child, while hospital confined, by a physician other than the delivering physician.

Limitation

Payment will be limited to the initial examination only. No payment will be made for charges for which benefits are payable elsewhere under the plan.

Medical Emergency Benefit (You will be paid 90% for the following, subject to the Stop Loss limits shown on page 2 in this booklet.)

How much

In the event of a medical emergency requiring care by a legally qualified physician whose services are not otherwise covered by the Plan, the Employee will be covered for the physician's charges up to a maximum of $30 for each emergency which shall include all complications arising from the same condition or incident. A "medical emergency" is defined as the sudden and unexpected onset of a condition requiring medical (not surgical) care which the Employee or Dependent obtains immediately after the onset or as soon as possible after the onset. Medical emergencies are limited to heart attacks, cardiovascular accidents, poisoning, convulsions, diabetic reactions, severe allergic reactions resulting in acute respiratory distress, loss of consciousness and such other acute conditions as may be determined by the Equitable to be medical emergencies.

Not covered

Charges for dental work or treatment.

Diagnostic X-Ray and Laboratory Benefits (You will be paid 100% for the following.)

Covered expenses

Benefits are payable for charges for Diagnostic X-ray and Laboratory examinations made or recommended by a legally qualified physician, provided such examinations did not result from causes connected with employment. This benefit will include charges for CAT SCAN procedures (head or other bodily areas).

How much?

Payment will be made on a Usual and Customary basis. Usual and Customary is defined in General Provisions.

Not covered

Charges incurred while confined to a hospital; charges for eye or ear examination, or examination of the teeth or periodontium unless the examination is made for diagnosis of an injury.

Physiotherapy Benefits (You will be paid 100% for the following.)

When benefits are payable

Benefits are payable for physiotherapy services when such services are performed in the out-patient department of a legally constituted hospital by a qualified physiotherapist, provided that a legally qualified physician has certified that such physiotherapy is necessary for treatment of an illness or injury not connected with employment.

How much?

You will be paid up to $20.00 per treatment subject to a maximum limit of 15 treatments for any illness or any and all injuries sustained in one accident.

Not covered
Charges for treatment in connection with a chronic condition; charges for rental or purchase of braces, prosthetic appliances or other durable equipment; charges payable elsewhere under your Group Insurance Program; the fees of a physician therapist or for any other professional fees; charges for more than one treatment per day.

Radiation Therapy Benefits (You will be paid 100% for the following.)

When benefits are payable

Benefits are payable for X-Ray, radium or external radiation therapy treatment performed by a legally qualified physician or radiologist for any condition set forth in the Radiation Therapy Schedule as set forth on the following pages.

How much?

You will be reimbursed in accordance with the following Schedule. If more than one treatment is received on any one day, payment will be limited to the treatment which qualifies for the highest maximum amount as determined by the Schedule.

RADIATION THERAPY SCHEDULE
(No payment will be made for conditions not listed)

Condition Treated by roentgen ray, betatron or external application of radium	Maximum Payment Per Day of Treatment	Maximum Payment Per Condition
Proven Malignancy		
1. HEAD AND NECK		
Brain and pituitary	$ 22.50	$450.00
Oral and nasal cavity	16.88	337.50
Pharynx	16.88	337.50
Larynx	16.88	337.50
Thyroid	16.88	337.50
2. CHEST		
Primary broncho-pulmonary malignancy	16.88	337.50
3. ABDOMEN		
Gastro-intestional tract		
Esophagus	16.88	337.50
Stomach	16.88	337.50
Colon	16.88	337.50
Genito-urinary tract		
Ureters	16.88	337.50
Bladder	22.50	450.00
Testicle and regional nodes	22.50	450.00
Kidneys	16.88	337.50
Prostrate and regional nodes	16.88	337.50
Penis and regional nodes	16.88	337.50
Gynecological tract		
Uterus and adnexa	22.50	450.00
4. BREAST		
Unilateral	16.88	337.50
Bilateral	22.50	450.00
5. MISCELLANEOUS		
Bone	16.88	337.50
Leukemia	11.25	225.00
Myeloma	16.88	337.50
Spinal cord	16.88	337.50
Polycythemia vera	11.25	225.00
Lymphomas (malignant or benign)	16.88	337.50
6. SUPERFICIAL (skin and lips)		
Malignant lesions without metastasis	7.50	75.00

RADIATION THERAPY SCHEDULE (Continued)

Condition Treated by roentgen ray, betatron or external application of radium	Maximum Payment Per Day of Treatment	Maximum Payment Per Condition
Proven Malignancy (Continued)		
6. SUPERFICIAL (skin and lips) (Continued)		
Malignant lesions with metastasis	$ 22.50	$112.50
Non-Malignant Conditions		
1. TUMORS		
Brain and pituitary	$ 22.50	$450.00
Bone	16.88	337.50
Spinal cord	16.88	337.50
2. HEMANGIOMA AND VASCULAR NEVI	7.50	75.00
3. BURSITIS	7.50	75.00
Treatment of Proven Malignancy by oral administration, parenteral or intracavitary injection of radioactive isotopes.		
Initial treatment	75.00	
Each additional treatment	37.50	
Maximum for all such treatments of any one malignancy		225.00
Treatment of Proven Malignancy by implantation of radium or radon seeds by endoscopy (excluding cost of radioactive material).		
Up to 3 seeds	$ 37.50	
4 to 8 seeds	75.00	
9 to 13 seeds	112.50	
14 to 18 seeds	150.00	
18 and over	225.00	

Not covered

Charges which result from diagnostic procedures and those for conditions not listed in the schedule; charges for the purchase, rental or cost of radium or other radioactive materials; for the use of roentgen rays or the rays of other radioactive material for diagnostic purposes or charges which are covered under any other portion of the Transmission Systems Group Insurance Plan.

Convalescent & Long-Term Illness Benefits (You will be paid at 90% for the following, subject to the Stop Loss limits shown on page 2 in this booklet.)

When benefits are payable

Benefits are payable for confinement as a registered bed patient in an Extended Care Facility (as defined below) due to injury or long-term illness, provided such confinement occurs within 14 days of a confinement which has lasted a minimum of 3 days in a legally constituted hospital and that such Extended Care confinement was for the same or related cause as the previous hospital confinement. In the case of confinement for mental illness, transfer from the legally constituted hospital must be immediate.

(EXTENDED CARE FACILITY. The term extended care facility means a convalescent chronic disease facility or nursing home, whether operated independently or as part of a general hospital, which is accredited by the Joint Commission on Accreditation of Hospitals or is recognized as an Extended Care Facility by the Secretary of Health, Education and Welfare of the United States pursuant to Title XVIII of the Social Security Act of 1965, as amended, provided that such facility is approved by Equitable at the time confinement commences.)

How much does plan pay?

You will be paid:

1. The full cost of Bed and Board charged by the Facility for a ward or a semi-private room. If a private room is used the allowance will be equal to the average charge made by the Facility for a two-bed room. However, the daily benefit payment should not exceed the most common charge for a two-bed room of the legally constituted hospital to which the patient was confined immediately prior to his confinement in the Extended Care Facility.

2. The charge made for necessary services and supplies by the Extended Care Facility (other than nurses' fees or physicians' fees) upon the recommendation of a legally qualified physician.

How long?

The maximum number of days for which you may receive payment is based on a two year period (730 days). For primary mental illness the maximum period is 90 days.

To determine the actual number of days for which you are eligible under this benefit, the 730 or 90 day figure must be reduced by 2 days for each day of confinement in the legally constituted hospital for the same condition.

For retired employees age 65 and over the two-day reduction clause does not apply for the first 100 days of confinement in the Facility.

Not covered

No benefit will be paid for:

Confinement in an institution used principally as a rest facility or facility for the aged, drug addicts, or alcoholics or primarily for custodial or domiciliary purposes; confinement for tuberculosis, mental retardation, senility or similar conditions not subject to favorable modification by medical treatment; charges for unnecessary care or treatment.

Successive periods of confinement in an extended care facility resulting from the same injury or same or related sickness will be considered one period of continuous confinement unless they are separated by 6 months, or in the case of an active employee, by his/her return to work.

Doctor's visits during confinements in an Extended Care Facility (You will be paid at 90% for the following, subject to the Stop Loss limits shown on page 2 in this booklet.)

Benefits are payable for charges by a legally qualified physician for treatment received. Payment will be made for only one visit per day and limited to two visits per week. Benefits for visits are payable up to the following amounts:

1st Visit	$15.00
2nd Visit	10.00
3rd Visit through the 10th Visit	4.00 per visit
11th Visit and thereafter	3.00 per visit

Not covered

No payment will be made for the physician who is responsible for the supervision of the Facility, unless he is in charge of the patient's case. Payment will not be made for charges for treatment in connection with the teeth or periodontium, eye or ear examinations, nursing services, drugs, dressings, or medicines, or for fees charged for treatment received after an operation is performed.

Out-Patient Psychiatric Care Benefits

When benefits are payable

Benefits are payable for Psychiatric Services for treatment of mental illness or functional nervous disorders, when such services are performed at: (a) an Out-Patient Psychiatric Facility, upon recommendation of a qualified physician, and (b) for charges for such services billed by a physician (or in the case of psychological testing, by a Psychologist).

How much?

You will be paid a percent of Actual Charges Considered a Covered Expense under the following Schedule of Out-Patient Psychiatric Care Benefits subject to a maximum limit of $1,000 per patient per calendar year.

OUT-PATIENT PSYCHIATRIC CARE SCHEDULE

	Psychiatric Service	% of Actual Charge Considered a Covered Expense	Maximum Payment Not to Exceed
A-1	Out-Patient Psychiatric Facility	100%	$30.00 for each day on which a visit is made or overnight confinement occurs.
A-2	Electro-shock Therapy and Anesthesia for Electro-shock Therapy		
	Initial	100%	$50.00 per treatment
	Subsequent	100%	$40.00 per treatment
A-3	Prescription Drugs and Medication dispensed by Out-Patient Psychiatric Facility (as of January 1, 1970 this will not apply to individuals insured for Prescription Drug Benefits)	100%	$ 5.00 per prescription
*A-4	Psychological Testing	100%	$76.50 per 12 consecutive months
A-5	Visits by Members of Patient's immediate Family for counseling by other than Qualified Physician	100%	$10.00
B-1	Full Psychotherapeutic Session (50 minutes)		
	1st through 5th Sessions	100%	$50.00 per session
	6th through 10th Sessions	85%	$42.50 per session
	11th through 15th Sessions	70%	$35.00 per session
	16th and subsequent Sessions	55%	$27.50 per session

OUT-PATIENT PSYCHIATRIC CARE SCHEDULE (Continued)

	Psychiatric Service	% of Actual Charge Considered a Covered Expense	Maximum Payment Not to Exceed
B-1	Full Psychotherapeutic Session (50 minutes) (Continued)		
	Half Psychotherapeutic Session (20 minutes to 50 minutes)		
	1st through 5th Sessions	100%	$30.00 per session
	6th through 10th Sessions	85%	$25.50 per session
	11th through 15th Sessions	70%	$21.00 per session
	16th and subsequent Sessions	55%	$16.50 per session
B-2	Group Psycholtherapeutic Sessions	85%	$ 8.60 per session
B-3	Visits by Members of Patient's Immediate Family		
	Patient 19 years of age or more	85%	$42.50 per full session $25.50 per half session Maximum of 5 visits per patient
	Patient less than 19 years of age		
	1st through 5th visit	100%	Same as B-1 depending on whether full or half session
	6th through 10th visit	85%	
	11th through 15th visit	70%	Maximum of 20 visits per patient
	16th through 20th visit	55%	
*B-4	Psychological Testing	85%	$76.50 per 12 consecutive months
B-5	Limited Treatment in Out-Patient Psychiatric Facility	100%	$10.00 per day on which visit is made

* Combined benefits under A-4 and B-4 not to exceed $76.50 in any 12 consecutive months.

OUT-PATIENT PSYCHIATRIC CARE SCHEDULE (Continued)

LIMITATIONS. No payment will be made for expenses incurred for

(1) psychiatric services rendered in connection with emotional and personality disorders and illness not classified as such in the International Classification of Diseases of the U.S. Department of Health, Education and Welfare (V. Psychoneurotic and Personality Disorders No. 300-329, as amended);

(2) psychiatric services extending beyond that period of time reasonably necessary, according to generally accepted professional standards, to evaluate the patient's disorders and illness and determine whether the same is amenable to favorable modification by accepted psychiatric treatment.

For the purpose of determining the appropriate percentage of the actual charge which is considered a covered expense, a resumption of psychiatric sessions within a period of twenty-four months shall be considered to be a continuation of the original series of treatment sessions. Each session, regardless of duration, shall be counted as one session.

Covered Expenses	Subject to certain provisions and qualifications, the following are considered as covered charges: 1. Professional Staff and ancillary services of Out-Patient Psychiatric Care Facility 2. Drugs dispensed by Out-Patient Facility 3. Services of other qualified physicians 4. Electro-shock and anesthesia therefor 5. Psychological testing by qualified psychologist 6. Counseling visits of patient's family.
Not covered	Psychiatric Services for untreatable mental deficiencies or retardation; services which cannot, according to generally accepted professional standards, reasonably be expected to achieve a favorable modification of the emotional or personality disorder or illness of the patient. Psychiatric services provided without cost to the employee or dependent under any health care program supported in whole or in part by Funds of the Federal Government or any state or political subdivision thereof or which would be so provided if no insurance coverage existed; services provided elsewhere under the Group plan.

Prescription Drug Benefits

Definitions

Prescription Legend Drug means any medicinal substances, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "CAUTION: Federal Law Prohibits Dispensing Without A Prescription," and injectible insulin.

Physician shall mean a doctor of medicine, a doctor of osteopathy or a podiatrist, a doctor of dental surgery or a doctor of dental medicine, legally licensed to prescribe medications within the scope of his license.

Provider means any pharmacy, physician, dentist, or any other person or organization legally licensed to dispense Legend Drugs.

Prescription order shall mean the request for each separate drug or medication by a Physician or Dentist and each authorized refill of such order.

What is covered?

Covered Drug Charges are those incurred while insured and on account of accidental bodily injury or sickness not connected with employment. These charges shall only include the usual and customary charges which are in excess of the deductible amount.

What are covered drug charges?

Covered Drug Charges consist of charges for Legend Drugs and injectible insulin when dispensed by a physician or a licensed pharmacist upon written prescription order, and needles and syringes for the injection of insulin in a quantity relative to the amount of insulin dispensed.

How much?

Covered Drug Charges in excess of $4.00 per NON-GENERIC prescription will be reimbursed. The GENERIC deductible is $2.00 per prescription or refill.

Maximum quantities

Benefits will not be paid for drugs dispensed in quantities greater than a 34-day supply with the exception of Maintenance Legend Drugs which may be dispensed in accordance with the following table:

Maximum quantities (Continued)

Maintenance Legend Drugs to be Dispensed in Maximum Quantities of 34-Day Supply or 100-Unit Doses; Whichever is Greater

Acetazolamide	Metolazone
Acetohexamide	Nitroglycerin
Allopurinol	Pentaerythritol Tetranitrate
Bendroflumethiazide	Phenylbutazone
Benzthiazide	Polythiazide
Chlorothiazide	Potassium Chloride Liquid
Chloropropamide	Primidone
Colchicine and Colchicine-Probenecid	Probenecid
Conjugated Estrogens U.S.P.	Propranolol Hydrochloride
Digitalis Leaf	Quinidine Sulfate
Digitoxin	Reserpine
Furosemide	Spironolactone
Gitalin	Tolazamide
Hydrochlorothiazide	Tolbutamide
Methychlothiazide	Triamterene
Isoniazid	Trichlormethazide
Natural Thyroid	Para-Aminosalicylic Acid
Levothyroxine	Phenytoin (Diphenylhydantoin)
Liothyronine	Thyroglobulin
	Propylthiouracil

Not covered

Covered Drug Charges shall not include expenses incurred:

1. for drugs during a period of hospital confinement;

2. for drugs or medicines lawfully obtainable without the Prescription Order of a Physician or Dentist;

3. for that portion of the charge which is in excess of the usual and customary charges for the drug or medicine dispensed;

4. for contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (e.g., hypodermic needles and syringes except as provided for the injection of insulin, support garments, and other non-medical substances) regardless of their intended use;

5. for the administration of Prescription Legend Drugs or Injectible Insulin;

6. for any prescription refill in excess of the number specified by the Prescription Order, or any refill dispensed after one year from such order;

7. for which the employee or dependent is entitled to receive reimbursement under Worker's Compensation Laws or is entitled to without charge under any local, state or federal government programs;

Not covered (Continued)

8. for drugs for which a benefit is payable under another part of these Basic Hospital and Medical Benefits.

How do you file a claim?

If you take your prescription to a provider which has agreed to participate through Pharmaceutical Card System, Inc. (PCS) in the prescription drug plan of Borg-Warner Corporation:

1. Be prepared to pay up to $4.00 for NON-GENERIC or $2.00 for GENERIC, and

2. if the cost of a prescription exceeds the stated deductible present your PCS plastic identification card to the provider and complete and sign the upper right-hand section of the provider's claim voucher.

If you take your prescription to a provider which is not a participating PCS Member:

1. obtain a prescription drug direct reimbursement claim form from your Insurance Office, take it to the provider;

2. if the cost of the prescription exceeds the stated deductible fill-out the employee portion, have the provider complete the pharmacy portion;

3. pay the provider for the full cost of the prescription;

4. mail the completed form to PCS for processing.

Chemotherapy Benefits

Hospital Charges (In-Patient or Out-Patient) For Chemotherapy

Chemotherapy benefits are provided on both a hospital in-patient and out-patient basis to cover malignancies, provided that such conditions are treated according to the rules and regulations of the hospital. The therapy includes use of any equipment, supplies and facilities required for proper administration of the chemotherapeutic agent, provided that such medication has been accepted for inclusion in the U.S. Pharmocopeia, National Formulary, or has been accepted by the Federal Drug Administration and/or has received official approval by the American Medical Association Council on Drugs.

The application of experimental or research chemotherapeutic drugs and/or the use of any equipment associated with chemotherapy rendered in the home are not covered benefits.

Intra-arterial infusion chemotherapy

a. Intra-arterial infusion chemotherapy is the use in cancer therapy of a mechanical pump to infuse various medicaments at a controlled rate through a catheter placed surgically in an artery of an arm or a leg.

Intra-arterial infusion chemotherapy (Continued)

b. Benefits will be allowed when provided at the hospital and treatment is not on an investigative or research basis. Usage of equipment in the home is not a covered benefit.

Medical care for chemotherapy

Chemotherapy is the treatment of malignant diseases by chemical antineoplastic agents. Therapy involves administering the agents at a controlled rate through a catheter placed surgically in an artery.

When benefits are payable

Benefits are payable for separate administration of in-patient Chemotherapy in lieu of an in-patient medical day benefit, when rendered by a physician. Benefits are also payable for hospital out-patient and physician's office Chemotherapy. Coverage is for the following categories of therapy:

a. Parenteral (excluding subcutaneous or intramuscular);

b. Infusion (continuous or intermittent);

c. Perfusion; and

d. Intracavitary.

Benefits are also provided for up to three follow-up visits following each treatment (limited to one such visit per week). A follow-up visit is defined as a scheduled visit which would have resulted in the administration of a chemotherapy treatment except for medical complications which caused a postponement in the administration of the treatment.

Covered chemotherapy drugs

Covered Chemotherapy drugs (antineoplastic agents) are those which have been accepted for inclusion in the U.S. Pharmacopeia, National Formulary, or has been accepted by the Federal Drug Administration and/or has received official approval by the American Medical Association Council on drugs.

Not covered

Benefits are not provided for oral Chemotherapy, subcutaneous or intramuscular injections of drugs, experimental or research Chemotherapy drugs (antineoplastic agents), or administration in the home.

Vision Care Benefits

Definitions

"Opthalmologist" means any licensed doctor of medicine or osteopathy legally qualified to practice medicine, including the diagnosis, treatment, and prescribing of lenses related to conditions of the eye.

"Optometrist" means any person legally licensed to practice optometry as defined by the laws of the state in which the service is rendered.

"Optician" means one who makes or sells eyeglasses prescribed by an ophthalmologist or optometrist to cure or correct defects in the eyes, and grinds the lenses or has them ground according to prescription, fits them into a frame, and adjusts the frame to fit the face.

"Participating Provider" means an opthalmologist, optometrist, or optician who has signed an agreement with the Equitable to provide frames to individuals insured for this coverage.

"Nonparticipating Provider" means an ophthalmologist, optometrist, or optician who has not signed an agreement with the Equitable to provide frames to individuals insured for this coverage.

"Contact Lenses" means opthalmic corrective lenses, as prescribed by an opthalmologist or optometrist, to be fitted directly to the patient's eyes.

"Lenses" means ophthalmic corrective lenses, as prescribed by an opthalmologist or optometrist, to be fitted into a frame.

"Frame" means a standard eyeglass frame into which two lenses are fitted.

"Covered Vision Expense" means the Usual and Customary Charge for vision care services and materials, as described below when provided by ophthalmologist, optometrist, or opticians.

Covered vision expenses

A. Vision Examinations:

1. Refraction, including case history, coordinating measurements, and tests;

2. The prescription of glasses where indicated; and

3. Examination by an ophthalmologist, upon referral by an optometrist, within sixty days of a vision examination by the optometrist.

Covered vision expenses (Continued)

B. Lenses and Frames:

When lenses are prescribed by an ophthalmologist or optometrist, the necessary materials and professional services connected with the ordering, preparation, fitting, and adjusting of:

1. Lenses (single vision, bifocals, trifocals, lenticular). If the individual selects lenses, the size of which results in an additional charge, only the Reasonable and Customary Charge for normal size lenses of the same material and prescription will be considered a Covered Vision Expense. If the individual selects photochromic lenses or lenses with a tint other than Number 1 or Number 2, only the Usual and Customary Charge for clear glass lenses of the same prescription will be considered a Covered Vision Expense.

2. Contact lenses following cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye except by their use, or when medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature. If contact lenses are prescribed for any other reason, $35 is the maximum amount that will be considered a Covered Vision Expense.

3. Frames. If frames are obtained from a Participating Provider, the individual may make a selection from the display shown by the Participating Provider and there will be no out-of-pocket expense to the individual other than as described under "Co-Payments." However, if the selection at the Participating Provider is not from the display shown, or if the individual obtains frames from a Nonparticipating Provider, $15 is the maximum amount that will be considered a Covered Vision Expense.

Co-payment

For each person, there is a $5.00 co-payment applicable to the Covered Vision Expense for each vision examination and a $7.50 co-payment for the combined Covered Vision Expenses for lenses, contact lenses, and frames. The total copayment for each person, during any period of 12 consecutive months, will not exceed $12.50.

How much

Benefits will be paid up to the usual and customary charge for Covered Vision Care Expenses, less the applicable Co-Payment amount.

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How much (Continued)

Benefit amounts will change as of the dates shown below:

Type of Expense	Plan pays actual charge up to a maximum of
Complete exam	1/1/87 = $30.00 1/1/88 = $30.00 1/1/89 = $30.00
Lenses:	
Single Vision	1/1/87 = $35.00 per pair 1/1/88 = $40.00 per pair 1/1/89 = $45.00 per pair
Bifocal	1/1/87 = $45.00 per pair 1/1/88 = $50.00 per pair 1/1/89 = $55.00 per pair
Trifocal	1/1/87 = $55.00 per pair 1/1/88 = $60.00 per pair 1/1/89 = $65.00 per pair
Contact Lens	1/1/87 = $35.00 per pair 1/1/88 = $40.00 per pair 1/1/89 = $45.00 per pair
Medically Prescribed Contact Lens	1/1/87 = $65.00 per pair 1/1/88 = $70.00 per pair 1/1/89 = $75.00 per pair
Frames	1/1/87 = $35.00 per pair 1/1/88 = $40.00 per pair 1/1/89 = $45.00 per pair ← Dick, is $45 correct or should it be $40 ?

Frequency limitations

For each person, there are the following limitations on the frequency with which charges for certain services and materials will be considered Covered Vision Expenses:

Vision Examination	- Once during any period of 12 consecutive months, except as provided in Section A.3.
Lenses and Contact Lenses	- One pair during any period of 12 consecutive months.
Frames	- Once during any period of 24 consecutive months.

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Frequency limitations (Continued)

Effective January 1, 1987, for each person there are the following limitations on the frequency with which charges for certain services and materials will be considered Covered Vision Expenses:

Vision Examination	- Once per calendar year, except as provided in Section A.3.
Lenses and Contact Lenses	- One pair per calendar year.
Frames	- Once during any two consecutive calendar years, unless there is medical documentation submitted to reflect that the frames were needed because the prescription required a different change that required new frames and lenses. However, no more than one new frame will be allowed per calendar year.

The limitations on lenses, contact lenses, and frames apply whether or not they are a replacement of lost, stolen, or broken lenses, contact lenses, or frames.

Not covered

No benefits will be paid for expenses incurred for:

A. Any lenses which do not require prescription;

B. Medical or surgical treatment of the eye;

C. Drugs or any other medication;

D. Procedures determined by the carrier to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography;

E. Vision examinations or materials furnished for any condition, disease, ailment, or injury arising out of or in the course of employment;

F. Vision examinations performed and lenses and frames ordered:

1. Before the covered individual became insured for this coverage;

2. After the termination of the covered individual's coverage;

3. To the extent that they are obtained without cost.

SECTION III - MAJOR MEDICAL EXPENSE BENEFITS

Purpose of these benefits

Major Medical coverage is designed to pay a substantial portion of the excessive expenses which may result from a serious accidental bodily injury or illness not connected with employment. Hospital Confinement is not necessary to be eligible for benefits.

Amount of benefits

Payment will be made for 80% of all Covered Charges incurred during a Benefit Period in excess of the deductible amount, except as explained under the paragraph entitled "Psychiatric Treatment." Such Covered Charges shall include only the usual and customary charges for the service, supplies and treatment furnished. Benefits will be paid under this plan up to a maximum of $200,000 with respect to any one individual in his lifetime.

If an individual has less than $200,000 of benefits remaining on any January 1, then an automatic reinstatement of benefits is made in an amount equal to the lesser of

1. $1,000, and

2. the amount necessary to increase benefits to $200,000.

For an individual who has received benefits of $1,000 or more, the full maximum of $200,000 may be reinstated at the time the Insurance Company receives satisfactory evidence of insurability.

What are covered expenses?

1. Charges for services by a legally constituted and operated hospital.

2. Charges made by a physician legally licensed to practice medicine and surgery for diagnosis, treatment and surgery.

3. Private duty nursing service charges of a Registered Nurse.

4. Charges for local ambulance service, equipment, medication, appliances, X-Ray services, laboratory tests, the use of radium and radioactive isotopes, oxygen, iron lung, physiotherapy and similar services, supplies and treatment.

5. Oral Surgery charges by a Doctor of Dental Surgery for cutting procedures for the treatment of diseases or injuries of the jaw or the extraction of impacted teeth if performed while the insured person is confined in a hospital for at least 18 hours.

Charges not covered

1. Charges for services, supplies and treatment unless prescribed by a physician legally licensed to practice medicine and surgery, or, if Oral Surgery is performed, by a Doctor of Dental Surgery.

2. Charges in connection with dental work or treatment, tooth extractions, or dental x-rays, unless such charges are (a) hospital charges incurred while confined, (b) for oral surgery as provided above, or (c) incurred as a result of accidental injury to sound natural teeth occurring while insured.

3. Charges incurred in a Federal Hospital or because of war.

4. Charges for eye refractions, the fitting or cost of eyeglasses and hearing aids, transportation (except local ambulance service), health examinations (except in connection with accidental injury or illness).

5. Maternity charges of a dependent child except complications in connection with pregnancy, resulting childbirth, miscarriage or abortion. In determining the amount of benefits payable, charges due solely to the complications will be considered.

Benefits will not be paid for, and the term "covered charges/expenses" ... are payable under the Organ or Tissue Transplant Benefit.

Deductible amount

The deductible amount for each individual during any period of six consecutive months of a calendar year will be the sum of:

1. a cash deductible of $125, effective October 1, 1986. If prior to October 1, 1986, you met the previous deductible of $100, you do not have to meet the $125 deductible. If prior to October 1, 1986, you did not meet the previous deductible of $100, then the $125 deductible must be met, and

2. the amount paid under the Basic Hospital and Medical Benefits.

The cash deductible applies only once in any calendar year even though you may have several different accidents or illnesses; however, the expenses used to satisfy such deductible must be incurred within six consecutive months of a calendar year, subject to the liberalization described in the following paragraph.

So that your Major Medical claim will not be subject to a deductible late in one calendar year and again on January 1 of the following year, any portion of the deductible satisfied from October 1 through December 31 will be used to reduce the deductible applicable to the first six months of the following calendar year.

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Maximum family deductible (Effective January 1, 1987, this benefit will no longer apply.)

If three members of a family each satisfy their cash deductible during a calendar year, then any remaining portion of the cash deductible for the calendar year will be waived for all other members of the same family with respect to expenses incurred after such family deductible has been satisfied.

What is a benefit period?

A Benefit Period is the period of time during which an insured person may receive benefits with respect to such injury or illness.

It begins with respect to an individual when, during a period of six consecutive months or less, he accumulates Covered Charges in excess of the Deductible Amount.

It ends on the earliest of

1. the December 31 of the calendar year in which it begins, or

2. the date insurance terminates.

Common accident

If two or more persons insured as members of a family incur Covered Charges as a result of the same accident, only one combined cash deductible of $125, will be applied to the calendar year in which the accident occurs for all such members of the family.

However, such cash deductible must be established within six consecutive months of the calendar year. It will be re-applied beginning with the following calendar year.

Once the $125 combined deductible is satisfied, benefits for each person will be determined separately.

If a family member involved in a common accident should incur Covered Charges not related to said accident, he will be required to satisfy the applicable deductible amount less his portion of the common accident cash deductible. However, in order for this to apply, this combination deductible (common accident and the portion not related to the common accident) must be satisfied within the same consecutive six month period of a calendar year.

Any portion of any cash deductible satisfied from October 1 to December 31 will be used to reduce the cash deductible to the first six months of the following calendar year.

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Psychiatric treatment

Covered Charges incurred in connection with professional fees for psychiatric treatment while not confined to a hospital shall not include fees in excess of $20 per visit with payment limited to 50% of such Covered Charges, subject to a maximum payment of $10 per visit and a maximum total payment of $500 during any one period of 12 consecutive months. However, such fees of a practitioner other than a physician legally licensed to practice medicine and surgery shall not be covered.

Dick, Is this benefit applicable retiree?

SECTION IV - MEDICAL CASE MANAGEMENT

What is Medical Case Management

Medical Case Management is a program to control high health care costs connected with a severe personal injury or sickness. "Severe personal injury or sickness" means any of the following which result in the person becoming totally disabled: major head trauma, spinal cord injury, amputations, multiple fractures, severe burns, neonatal high risk infants, severe stroke, multiple sclerosis, amyotrophic lateral sclerosis, end stage cancer, acquired immune deficiency syndrome.

The objectives of this program, once the acute stage of an illness of injury is past and the patient has stabilized, are to find and cover care effective and cost effective medical alternatives. Medical alternatives means rehabilitation services and supplies which:

- o may not be covered under other parts of the plan;
- o can be used in place of other services and supplies that are covered elsewhere; and
- o are more appropriate and less costly in the long term care of the patient.

The flexibility of this program allows all options of care to be explored and considered for coverage based on each specific case.

When the program begins

The program will begin when an insured person suffers a severe personal injury or sickness and your employer and the Equitable agree, based on an objective review of:

- o the person's medical status;
- o the current treatment plan;
- o the projected treatment plan;
- o the long term cost implications; and
- o the effectiveness of care,

that benefits under this program should be paid because the objectives of the program will be met.

How benefits under the program will be paid

Benefits under this program will be paid in accord with the following provisions:

- Benefits will be paid for usual and customary charges for the rehabilitation services and supplies furnished to the patient.
- Benefits will be paid to the extent that they are in excess of the total benefits payable for such charges under all other parts of the plan.
- The injury or sickness must happens and all charges must be incurred while the patient is covered under the plan.
- The amount of the benefit payment for these charges will be determined by the Equitable.
- The maximum benefit is subject to the overall ~~lifetime~~ maximum under the ~~Comprehensive~~ Health Insurance Plan.

SECTION VI PARTICIPATING IN THE PLAN

Who is eligible

You are eligible to participate in this plan if you:

- o are a retired employee of Borg-Warner AUTOMOTIVE, INC., TRANSMISSION SYSTEMS
- o are covered, or eligible to be covered, by the group medical plan at ~~the Borg-Warner location where you had worked~~ TRANSMISSION SYSTEMS; and
- o on or before your retirement date, had elected to continue your health benefits under the retirement plan at the time of retirement.

Your eligible dependents are also eligible to participate in this plan.

Is this necessary?

Eligible dependents are your spouse and dependent children who are eligible for coverage under your ~~Borg-Warner~~ TRANSMISSION SYSTEMS group medical plan.

Deferred-vested employees, employees who were not insured for health benefits prior to retirement, or employees whose coverage terminated before _____ are not eligible to participate.

Eligible dependents include:

A. the lawful wife or husband of the RETIRED employee, and

B. any unmarried child of the RETIRED employee who is

(1) less than nineteen years of age, or who is nineteen years of age and less than twenty-five years of age and enrolled as a full-time student.

(2) not employed on a regular full-time basis,

(3) legally residing in the household of the RETIRED employee,

(4) dependent upon the RETIRED employee for more than one-half his support as defined by the Internal Revenue Code and either qualifies thereunder for dependency tax status in the current year or has qualified as a dependent on the employee's most recent Income Tax Return, and

C. any unmarried child of the RETIRED employee who has reached the limiting age (19 or 25 if a full-time student) while insured and who is

(1) permanently and totally disabled so as to be prevented from performing the duties of any occupation for wage or profit, and

DTP013910

Who is eligible (Continued)

(2) legally residing in the household of the retired employee and dependent upon the employee for more than one-half his support as outlined in paragraph B. above,

excluding any dependent child with respect to whom a retired employee was not insured on the day preceding retirement.

In the event that a retired employee's marriage is dissolved by court decree and the court decrees that the employee retain financial responsibility for medical care for any children of the marriage, such children will be considered as dependents of the retired employee provided they meet the requirements set forth in sub-sections (1) and (2) of section B. above or under sub-section (1) of section C. above, and legally reside in the household of one of the natural parents or are enrolled as full-time students in a school, college or university and are dependent upon one of the natural parents for more than one-half of their support as indicated in sub-section (4) of section B. above.

The term child will include a child born of the retired employee, a child legally adopted by the retired employee or a child with respect to whom the retired employee has initiated legal adoption proceedings, and a stepchild of the retired employee living with the retired employee in a normal parent-child relationship.

It is provided that no one may be a dependent who is eligible for the insurance as an employee and no one may be a dependent of more than one retired employee.

YOU SHOULD NOTIFY YOUR EMPLOYER EACH TIME THE NUMBER OF YOUR ELIGIBLE DEPENDENTS CHANGES.

Note

Mentally retarded or physically handicapped dependent children will be covered regardless of age.

Sponsored dependents

An insured employee may also insure eligible sponsored dependents by the employee paying the full cost of the coverage, and making application for "Sponsored Dependent" coverage.

A sponsored dependent is:

1. A person who is related to the employee by blood or marriage; or

2. If not related to the employee, resides with the employee as a member of his/her household; and

Sponsored dependents (Continued)

3. Dependent upon the employee for over half of his support and was reported as a dependent on the employee's most recent Federal Income Tax return, or qualifies in the current year for such dependency tax status (proof required).

Sponsored Dependents coverages exclude Major Medical and Vision and the use of the plastic PCS drug card for prescriptions (the card is not usable for dependents over 25 except employees spouse) but prescription can be covered by the "Direct Reimbursement" feature of the Prescription Drug Plan.

Becoming eligible for dependents insurance

Each employee will be eligible for Dependents Insurance on the later of:

1. the date the employee becomes insured, and

2. the date the employee acquires his first eligible dependent or sponsored dependent.

When coverage begins

Coverages under this plan will begin on THE EFFECTIVE DATE OF YOUR RETIREMENT.

Payment of claims

All claims must be reported promptly. Your employer has the forms required.

Occupational accidents and diseases

Benefits are not payable under the Basic Hospital and Medical, Major Medical or Vision coverages for occupational injuries or disease which are covered under any Workmen's Compensation or Occupational Disease Laws.

Coordination of benefits

If an individual covered under the Group Health Insurance Policy (hereinafter referred to as "this plan"), is also covered under one or more other Group Plans providing Hospital, Medical, Major Medical or Vision benefits or services, then the benefits payable with respect to him under this plan may be reduced by the benefits payable under all other plans so that the sum of the benefits will not exceed the total Allowable Expenses. Benefits payable under another plan include benefits which would have been payable had claim been duly made therefor.

DTP013912

Coordination of benefits (Continued)

"Allowable Expense " means any necessary, reasonable and customary item of expense at least a portion of which is covered under this plan.

A "Group Plan" is any employer group insurance coverage or other arrangement of coverage for individuals in a group which provides hospital, or medical benefits or services on an insured or an uninsured basis (other than Franchise insurance or no-fault motor vehicle coverage).

If, in coordinating the benefits of this plan with those of another plan, (a) the rules set forth in the following paragraph would require this plan to determine its benefits before the other plan and (b) the other plan which contains a provision non-duplication (or coordinating) its benefits with those of this plan would, according to its rules, determine its benefits after the benefits of that other plan will be ignored for the purposes of determining the benefits of this plan.

The rules establishing the order of benefit determination are:

(a) The benefits of a plan which covers the individual for whom claim is made other than as a dependent will be determined before the benefits of a plan which covers that individual as a dependent.

(b) The benefits of a plan which covers the individual for whom claim is made as a dependent of a male will be determined before the benefits of a plan which covers that individual as a dependent of a female. However, if the claim is made for a child of divorced or legally separated parents, the benefits of the plan which covers the parent who in the current year claims such child as a dependent for Internal Revenue Code purposes will be determined before the benefits of another plan, if any.

(c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a plan which has covered the individual for whom claim is made for the longer period of time will be determined before the benefits of a plan which has covered the individual for the shorter period of time.

For the purposes of Coordination of Benefits, the Insurance Company

(a) may release to or obtain from any other organizations or individuals any claim information, and any individual claiming benefits under this plan shall furnish the Insurance Company with any information which the Insurance Company may require;

(b) has the right, if an overpayment is made under this plan because of failure to report other coverage or other reason, to recover such overpayment from any individual or individuals to whom it was made;

Coordination of benefits (Continued)

(c) has the right to pay to any other organizations an amount it shall determine to be warranted, if payments which should have been made under this plan have been made by such organizations under other plans.

In order to obtain all benefits available, a claim should be filed under each plan.

Non-Duplication, Federal Medical or National Health

To the extent that coverage under this plan may be duplicated by coverage available under any Federal Medicare Program or plan of National Health Insurance now or later adopted, such duplicate coverage will be deleted from this plan.

Usual and customary

In determining what constitutes usual and customary the insurance company will take into consideration:

- the fees which fall within the customary range of fees charged in a locality by most providers of medical service of similar training and experience for the performance of a similar procedure or service, and
- unusual circumstances or medical complications requiring additional time, skill and experience in connection with the procedure or service.

Charges/fees/expenses

The term "charges", "fees", or "expenses", will not include the following items as determined by the Equitable:

(a) the amount, if any, in excess of what is reasonable and customary or the locality in which incurred, or

(b) any amount for a service, supply or treatment not recognized as generally accepted in medical practice as necessary for the diagnosis or treatment of the condition of the patient. In determining such amount the Equitable may consider the certification of an appropriate professional review organization or peer review committee regarding the extent to which the services, supplies, procedures and tests are necessary for the diagnosis and treatment of a patient's condition.

→ RIGHT OF RECOVERY

SECTION VII - TERMINATION OF INSURANCE

Your health insurance is continued until your death - unless you request termination of insurance.

The spouse of a deceased retired employee who was retired under the Retirement Income Program will have the Basic Hospital and Medical Coverages, and Major Medical benefits including coverage for eligible dependent children continued at no cost provided the spouse does not remarry and is receiving benefits under the Retirement Income Program provided the spouse and children were insured on the date of the employee's death. However, when such spouse becomes eligible for Medicare, claims will be calculated on the basis that such spouse has both Part A and Part B coverage, regardless of his/her actual status with Medicare.

The spouse of a deceased retired employee who is not receiving benefits under the Retirement Income Program may also continue the above coverages including coverage for eligible dependent children by paying the full cost of such coverages and remaining unmarried provided the spouse and children were insured on the date of the employee's death.

To the extent that premium payments are required in the preceding paragraphs, such payments must be made in advance of the fifth day of the month for which coverage is being provided.

All coverages terminate as indicated above or when you cease to be eligible, upon termination of employment status or when the group policy terminates, whichever is earlier.

Your dependents' insurance will continue - while you are living - until the date they no longer qualify as your eligible dependent, or until you request termination of dependent coverage.

Privilege on termination of insurance

Upon termination of your Group Hospital, Surgical and Medical Expense Insurance and that of your dependents the option of changing this insurance to an individual policy of insurance may be exercised. Such individual policy is obtainable, without furnishing evidence of insurability;

(a) by you, upon termination of your employment;

(b) by the surviving spouse, if you should die, provided the family is insured at your death;

(c) by a child, upon attaining the limiting age or upon marriage, while covered under the group plan;

Privilege on termination of insurance (Continued)

provided written application and the first premium payment is made to the Society within 31 days after termination of insurance. The form of individual insurance policy, the coverage thereunder, and all other terms and conditions thereof shall be as provided by the rules of the Society for such individual policy at the time of application. The individual policy, if issued, shall become effective upon the day following the date of termination of insurance under the Group policy.

THE EQUITABLE LIFE ASSURANCE SOCIETY
OF THE UNITED STATES

hereby certifies that, employees of

TRANSMISSION SYSTEMS
BORG-WARNER CORPORATION
(Herein called the Employer)

who are insured under Group Policy(ies) No. 15973L,H are, subject to the terms and conditions of said policy(ies), insured for the benefits described in the Benefits provision.

BENEFITS

The Equitable benefits for which you are insured are set forth in the pages of this booklet. Consult these pages for a further description of the terms and conditions of these coverages. If there is any coverage for which you are eligible which does not become effective unless you make the required election and contributory therefor, such coverage will not become effective unless you so elect and are making such contributions.

No assignment by you of any insurance under any coverage, except that covering medical expenses shall be valid.

This certificate, which is furnished in accordance with, and subject to, the terms of the Group policy(ies), replaces any other certificate previously issued to you covering the insurance described herein. It is not the contract of insurance. Each policy and the application of the Employer for it constitute the entire contract. This certificate is merely evidence of insurance provided under the policy(ies). The insurance is effective only after the person concerned is eligible for insurance and becomes and remains insured in accordance with the terms, provisions and conditions of each such policy.

RETIREE ? EMPLOYEE LIFE INSURANCE

Upon receipt of due proof of your death, the amount of Life insurance for which you are insured under the Group policy shall be payable to the beneficiary designated by you, as entered on the insurance records maintained in connection with the insurance under the policy. Any part of such insurance for no beneficiary is designated or surviving at your death will be payable in accordance with the terms of the policy.

THE EQUITABLE LIFE ASSURANCE
SOCIETY OF THE UNITED STATES

PF 26003(1a)(2) Amended by PF 18505

Protection after Termination

A. If your Group Life insurance terminates because you terminate employment in the class or classes of employees insured under the Group policy, you may, within thirty-one days after such termination of insurance, make application for any type of Individual Life insurance policy then customarily issued by the Equitable (except a policy of term insurance or a policy providing benefits in the event of total and permanent disability or additional benefits for accidental death). No medical examination is required and the policy will become effective thirty-one days after your Group Life insurance terminates, provided the premium is paid to the Equitable not later than such date. The amount you may convert may, at your option, be equal to or less than the amount terminated under the Group policy.

If you die within thirty-one days following termination of insurance as described in A. above, the Equitable will pay to your beneficiary the amount of Group Life Insurance you could have converted.

B. If your Group Life insurance terminates because the Group policy is terminated or amended, and you have been continuously insured under the Group policy for at least five years, you may also make application to convert your Group Life insurance to an Individual Life insurance policy upon the same conditions described in A. above. However, the maximum amount you may convert shall be the amount terminated under the Group policy less any amount for which you may become eligible under any other Group policy within thirty-one days after this Group Life insurance terminates, but in no event shall the amount you may convert be more than $2,000.

If you die during the thirty-one day period following the termination of your insurance as described in B. above and you have been continuously insured under the Group policy for at least five years, the Equitable will pay to your beneficiary the amount of insurance for which you were last insured under the Group policy less the amount for which you became insured under any other policy within thirty-one days after the date of such termination, but in no event shall such amount so payable be more than $2,000.

Accident and Health Insurance

Upon receipt of due proof of claim, Accident and Health benefits are payable to you.

Notice of Claim

Written notice of the event upon which claim may be based must be given to the Equitable at its Home Office in the City of New York within 20 days after the date of the loss for which claim is made. Failure to give notice within the time required by the policy shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice within the required time and that notice was given as soon as was reasonably possible.

Upon receipt of such notice, you will be furnished forms for filing proof of claim. If such forms are not furnished within fifteen days after the receipt of notice the claimant shall be deemed to have complied with the requirements of the policy as to proof of claim upon submitting within ninety days after the date of the loss for which claim is made, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proof of Claim

Written proof of claim must be furnished to the Equitable at its Home Office in the City of New York on the Equitable's forms within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within the time required by the policy shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within the required time and that proof was furnished as soon as was reasonably possible.

Examinations

The Equitable shall have the right and opportunity through its medical representative to examine any person when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

Legal Proceedings

No action at law or in equity shall be brought to recover under the policy prior to the expiration of 60 days after proof of claim has been furnished in accordance with the requirements of the policy, nor shall any such action be brought at all unless commenced within 2 years from the expiration of the time within which proof of claim is required by the provisions thereof.

Payment of Benefits

Payment of the benefits described in this plan will be made on the basis of your submission of proof that a charge, fee or expense has been incurred.

MW-BC- (8702)
Printed in U.S.A.

PF 26003(3) Amended by PF 18600

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SECTION VII - ORGAN OR TISSUE TRANSPLANT BENEFIT PLAN

About the plan

This benefit has been specifically designed to pay for charges for certain human to human organ and tissue transplants. It covers these charges when they are incurred while you or a dependent, as the recipient of the organ or tissue transplant, are insured by the plan.

The organ and tissue transplants covered by this plan are:

- bone marrow;
- heart;
- heart/lung;
- liver;
- lung;
- pancreas.

Benefits are payable if the recipient receives two opinions on the need for transplant surgery. The opinions must be given:

- by a board certified specialist in the involved field of surgery;
- in writing. The specialist must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the patient's condition.

What the plan covers

The plan covers charges for the following services in connection with a covered human to human organ or tissue transplant procedure:

- organ and tissue procurement. This consists of removing, preserving and transporting the donated part.
- transportation of the recipient and a companion to and from the site of the transplant. If the recipient is a minor, transportation of two persons who travel with the minor is included. Reasonable and necessary lodging and meal costs incurred in the interim by such companions are included. Itemized receipts for all these charges are required.
- hospital room and board and medical supplies.

What the plan covers (Continued)

- diagnosis, treatment and surgery by a doctor.
- private nursing care by: a Registered Nurse (R.N.); a Licensed Practical Nurse (L.P.N.).
- the rental of wheel chairs, hospital-type beds and mechanical equipment required to treat respiratory impairment.
- local ambulance service; medication; x-ray services and other diagnostic services; laboratory tests; oxygen.
- rehabilitative therapy consisting of: speech therapy (not for voice training or a lisp); audio therapy; visual therapy; occupational therapy; and physiotherapy.
- surgical dressings and supplies.

When benefits are payable

Benefits will be paid for covered transplant services when they are received by you or your dependent during what is called a transplant benefit period.

A transplant benefit period begins five days before the date of the organ or tissue transplant. It ends eighteen months after the organ or tissue transplant is done. But, if a covered transplant procedure is not done as scheduled due to the intended recipient's medical condition or death, benefits will still be paid for organ and tissue procurement, and for covered transportation, lodging and meal charges.

The plan pays for covered transplant services on a usual and customary basis. This means the plan will pay the full amount of the bill for covered transplant services (up to the plan maximums) -- as long as you have not been charged more than the prevailing fee for the services received.

If you are charged more than the usual and customary allowance for a covered transplant service, you are responsible for paying the entire part of the charge over the allowance.

Maximum plan payments

There is a $1,000,000 limit on how much the plan will pay for all covered transplant services for each covered person during his or her lifetime.

But, there are other maximums that apply to certain covered transplant services received during each transplant benefit period. These maximums are:

- $10,000 for charges for organ and tissue procurement.

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Maximum plan payments (Continued)

- $10,000 for charges for private nursing care.
- $10,000 for transportation, lodging and meals. There is also a daily limit on charges for lodging and meals of $200 per day.

Two or more transplant benefit periods

These are treated as follows:

- if they are due to unrelated causes, they are treated as separate periods.
- if they are due to related causes, they are treated as separate periods if:
  - in your case, they are separated by your return to active work; or
  - in the case of your dependent, they are separated by at least three months in a row.
- if they are due to related causes, they are treated as one period when not separated as shown above.

Not covered

No benefits will be payable for services:

- not ordered by a doctor.
- for which an insured person would not legally have to pay if there were no insurance.
- for an injury or sickness due to employment with any employer or self employment.
- for custodial care. This term means:
  - room and board and other institutional or nursing services which are provided for a person due to his or her age or mental or physical condition mainly to aid the person in daily living; or
  - medical services which are given merely as care to maintain the person's present state of health and which cannot be expected to improve a medical condition to a great extent.

Not covered (Continued)

- for an injury or sickness or for a related condition that existed within three months prior to the date the recipient becomes insured for the Organ or Tissue Transplant Benefit. This limit will not apply to expenses for that injury, sickness or related condition that were incurred after the first of these dates to occur:

  - the date after the person becomes insured for the Organ or Tissue Transplant Benefit when no charges were incurred for said injury or sickness for three months in a row;

  - in your case, at the end of six months in a row in which you were continuously insured for the Organ or Tissue Transplant Benefit and actively at work; or

  - the end of twelve months in a row in which the person was continuously insured for the Organ or Tissue Transplant Benefit.

PARTICIPATING IN THE PLAN

Who is eligible

You are eligible to participate in this plan if you:

- o are an active or retired employee ~~of Borg-Warner~~; and
- o are covered, or eligible to be covered, by the group medical plan ~~at the Borg-Warner location where you work (or where you had worked, in the case of a retired employee)~~.

Your eligible dependents are also eligible to participate in this plan.

Eligible dependents are your spouse and dependent children who are eligible for coverage under your ~~Borg-Warner~~ group medical plan.

When coverage begins

Your coverage begins on the later of

- o September 1, 1985; and
- o the date your coverage under the ~~Borg-Warner~~ group medical plan begins.

If you are not actively at work (or are confined in a hospital or other institution, in the case of a retired employee) on the day coverage would otherwise begin, your coverage will not begin until you return to active work (or, in the case of a retired employee, are discharged).

Coverage for your eligible dependents will begin on the later of:

- o the day your coverage begins; and
- o the day the dependent's coverage under your ~~Borg-Warner~~ group medical plan begins.

If a dependent is confined in a hospital or other institution on the day coverage would otherwise begin, coverage for that dependent will not begin until discharged. (This does not apply to a newborn child confined from birth.)

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